

KIMS Hospital

Quality Report

Newnham Court Way

Weaving

Maidstone

Kent

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

KIMS Hospital is operated by KIMS Hospital Ltd. The hospital has 99 beds, 68 of which are currently in use. Facilities include five operating theatres, an endoscopy suite, an interventional lab/suite, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, and outpatients and diagnostic imaging.

The hospital did not accept children under the age of 18 for surgery.

We carried out a focussed unannounced inspection at KIMS Hospital on the 4 and 5 September 2019. The hospital reported five serious incidents between August 2018 and September 2019. It was two of the most recent serious incidents that prompted the inspection. We wanted to check the leadership team had responded to these two incidents and to ensure the service was safe.

We inspected the core service of surgery and we focussed on two key questions, “Are services safe? and well-led”? We did not look at the other key questions relating to effective, caring, and responsive as this was a focussed inspection. Our findings did not affect the ratings we gave the hospital after our inspection in January 2018, when KIMS Hospital was rated as good overall.

For full details of the inspection undertaken in January 2018 please visit: <https://www.cqc.org.uk/location/1-1285831303/reports>

We found:

The hospital had a clear incident reporting process and staff had good knowledge of this. Staff were encouraged to report incidents and provided examples of learning.

The senior leadership team had undertaken thorough root cause analysis into the serious incidents. Areas requiring improvement such as standard of documentation had been identified and corrective actions taken.

There were effective processes which ensured areas requiring improvement were assigned to an individual and monitored for compliance.

The senior leadership team had engaged all staff in learning from the incidents and involved them in different work streams or projects.

The senior leadership team had created a culture of openness and transparency in the root cause analysis process and supported staff who were involved in the incidents.

Staff had been provided additional training and support in the implementation of actions from the root cause analyses. For example, additional training in undertaking neurovascular observations.

The senior leadership team had shared learning from the serious incidents with external organisations and stakeholders and had encouraged their feedback.

The senior leadership team had empowered staff to constructively challenge each other to drive and maintain improvement.

The hospital had researched and were in the process of implementing two different innovations designed to improve patient safety and a speaking up culture.

The service had an effective process which ensured consultants only operated within their scope of practice. There was an effective process to maintain contemporaneous records of all consultants employed under practicing privileges.

Summary of findings

The service had established different working groups and documentation champions to improve the standard of documentation. We found records were written and managed to keep people safe. They were clear, legible and risk assessments were completed in all the records we reviewed.

Staffing levels were planned and reviewed regularly by managers to keep patients safe. Managers and staff had a flexible approach to staffing and adjusted shifts to meet patient need.

Staff managed, stored and dispensed medicines safely and followed hospital policy and national guidance.

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

The sample of World Health Organisation checklists we saw were completed thoroughly and staff appeared fully engaged in the process.

The documentation of the anaesthetic machine safety checks was fully completed.

However, we also found the following issues that the service provider needs to improve:

We found patients records on Havisham ward which were not stored securely and were left unattended.

On Havisham ward, we found no designated box to place blood samples in.

We noted the sepsis screening tool was not included in the national early warning score 2 automatic trigger.

We asked the provider to seek assurance equality and diversity was promoted across the organisation.

In theatres, we found some drawn up emergency medicines in a fridge which had not been discarded from the previous day.

Nigel Acheson

Deputy Chief Inspector of Hospitals for the South East and London.

Overall summary

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating Summary of each main service

Good



The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. Staff collected safety information and used it to improve the service.

The senior leadership team had ensured structured root cause analyses had been undertaken of the serious incidents and maintained oversight of the actions resulting from these. They ensured changes were made quickly and staff were provided with opportunities for reflection and provided support and additional training if required.

Summary of findings

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Good 

KIMS Hospital

Services we looked at

We inspected the core service of surgery and we focussed on two key questions, “Are services safe? and well-led”? We did not look at the other key questions relating to effective, caring, and responsive as this was a focussed inspection. Our findings did not affect the ratings we gave the hospital after our inspection in January 2018, when KIMS Hospital was rated as good overall.

Summary of this inspection

Background to KIMS Hospital

KIMS Hospital is operated by KIMS Hospital Ltd. The hospital opened in 2014. It is a private hospital in Maidstone, Kent. The hospital primarily serves the communities of Kent. It also accepts patient referrals from outside this area. The hospital has 99 beds, 68 of which were in use at the time of the inspection, five purpose-built theatres, an endoscopy suite, an

interventional suite and outpatient and diagnostic facilities. The registered manager has been in post since 2016 and is also the controlled drugs accountable officer. The hospital had been inspected previously in January 2018 when it was rated good overall and good for the core service of surgery.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in surgery. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Why we carried out this inspection

We carried out a focussed unannounced inspection at KIMS Hospital on the 4 and 5 September 2019. The hospital reported five serious incidents between August

2018 and September 2019. It was two of the most recent serious incidents that prompted the inspection. We wanted to check the leadership team had responded to these two incidents and to ensure the service was safe.

How we carried out this inspection

We inspected the core service of surgery and we focussed on two key questions, “Are services safe? and well-led”? We did not look at the other key questions relating to

effective, caring, and responsive as this was a focussed inspection. Our findings did not affect the ratings we gave the hospital after our inspection in January 2018, when KIMS Hospital was rated as good overall.

Information about KIMS Hospital

The hospital has four wards and is registered to provide the following regulated activities:

- Surgical procedures
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Family planning services

The hospital did not accept children under the age of 18 for surgery.

During the inspection, we visited all the surgical wards in use, the pre-assessment unit and theatres. We spoke with more than 25 members of staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, allied health professionals, and managers. We spoke with one patient and one relative.

Summary of this inspection

The hospital had an on-site pharmacy. The hospital pharmacist team provided a daily service Monday to Friday between 8.30am and 5pm, and out of hours, staff were able to access the resident medical officer or senior nurse for pharmacy support and advice.

The hospital had four wards. Nickleby ward was open 24 hours a day and seven days a week. Of the 17 beds on Nickleby ward, five of them were adaptable for enhanced care. The enhanced care beds were used for patients where a higher level of post-operative support was anticipated, such as a patient with a history of a heart condition. The Havisham ward had 20 beds available for when the Nickleby ward became full. Copperfield ward was used for day case patients and consisted of 17 rooms.

Between September 2018 and August 2019, the most commonly performed procedures were injection into a joint (1,665 procedures), cataract surgery (681 procedures) and primary (first time) knee replacement (616 procedures).

In the reporting period September 2018 to August 2019 There were 10,330 inpatient and day case episodes of care recorded at the hospital; of these 6,413 were NHS-funded and 3,917 other funded.

Twenty-five percent of all NHS-funded patients and 26% of all other funded patients stayed overnight at the hospital during the same reporting period.

The accountable officer for controlled drugs was the registered manager.

Services accredited by a national body:

BUPA Accredited Breast care centre

BUPA Accredited Prostate centre

BUPA Accredited Cataract full pathway provider

Services provided at the hospital under service level agreement:

Maintenance of medical equipment

Histology

Resident Medical Officer provision

Translation services

Laundry

Non-routine blood tests

Specialist Microbiology

Blood transfusion services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We inspected the core service of surgery and we focussed on two key questions, “Are services safe? and well-led”? We did not look at the other key questions relating to effectiveness, caring, and responsiveness as this was a focussed inspection. Our findings did not affect the ratings we gave the hospital after our inspection in January 2018, when KIMS hospital was rated as good overall. References to ratings in this report relate to this earlier inspection.

Good



Are services effective?

As this was focussed inspection we did not inspect effective.

Good



Are services caring?

As this was focussed inspection we did not inspect caring.

Good



Are services responsive?

As this was focussed inspection we did not inspect responsive.

Good



Are services well-led?

We inspected the core service of surgery and we focussed on two key questions, “Are services safe? and well-led”? We did not look at the other key questions relating to effectiveness, caring, and responsiveness as this was a focussed inspection. Our findings did not affect the ratings we gave the hospital after our inspection in January 2018, when KIMS hospital was rated as good overall. References to ratings in this report relate to this earlier inspection.

Good



Surgery

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

Are surgery services safe?

Good 

As this was a focussed inspection we did not change the rating for safe. At the last inspection in 2018 safe was rated as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Managers received a weekly report on compliance with mandatory training and had oversight of training. Staff received an email when their mandatory training was due and instructions on how to book mandatory training. Staff could complete electronic mandatory training in their own time and would be reimbursed for the time.

The hospital set their target for mandatory training compliance at 95%. Ninety-nine percent of clinical theatre staff and 96% of non-clinical staff were up-to-date with mandatory training. Ninety-five percent of clinical ward staff and 98% of non-clinical ward staff were up to date with mandatory training. Ninety-seven percent of clinical staff in pre-assessment and 100% of non-clinical staff were up to date with mandatory training. All areas exceeded or were equal to the hospital target.

Staff who worked on Nickleby ward looking after patients in the enhanced care areas received additional training as part of their mandatory training.

Sepsis (severe infection) management was included in mandatory training. There was a hospital recognition, diagnosis and management sepsis policy which was in date and based on national guidance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training included female genital mutilation, human trafficking and modern slavery. Staff knew how to access the policies on the hospital's shared electronic drive. We reviewed both the hospital safeguarding for adults at risk policy and the safeguarding for children young people policy. Both were in date and referenced the latest legislation and guidance.

Hospital data showed 100% of staff in theatres had up-to-date training in safeguarding adults, levels one and 99% in level two, and 98% safeguarding children level one. The hospital did not accept children under the age of 18 for surgery. This meant all theatre staff had the relevant level of safeguarding children training in line with national guidance.

Hospital data showed 100% of ward staff and pre-assessment staff had up-to-date training in safeguarding adults, levels one and two, and safeguarding children level one.

The hospital was working towards all registered healthcare professionals to complete level three adult safeguarding training. This was in line with the intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018. Staff had been given until the end of

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the calendar year to complete the eight hours training stipulated within the intercollegiate document. At the time of the inspection 14% of theatre staff, 62% of ward staff and 84% of pre-assessment staff had completed level three training.

Senior nurses who carried the “7777” bleep who were in charge of the hospital site had undertaken level four adult safeguarding training. This ensured they had the knowledge to advise on and escalate any safeguarding concerns.

Staff told us who the hospital’s safeguarding lead was and described the process for reporting safeguarding concerns or how to seek advice. The safeguarding lead and deputy safeguarding lead held safeguarding vulnerable adults level three and four training, and safeguarding children level three children in line with national guidance.

We saw safeguarding flow charts with contact details were displayed throughout the hospital to remind staff of the processes for reporting concerns.

The hospital worked in partnership with other agencies to ensure service users were helped, supported and protected. The hospital hosted and attended regional safeguarding meetings which were multi agency and discussed real life scenarios and updates to guidance and legislation.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff followed infection control principles including the use of personal protective equipment such as gloves and aprons. Staff were ‘bare below the elbows’ to allow effective handwashing and we saw they adhered to infection control precautions such as using hand sanitiser before and after every time care was delivered.

All areas displayed signs reminding people to wash their hands or using hand sanitiser and guidance on how to do so. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff used “I am clean” stickers to indicate equipment had been cleaned and was ready for use.

The service undertook monthly 20-minute hand hygiene and bare below the elbow observational audits to check staff were compliant. Data supplied to us by the hospital showed 100% compliance between for June, July and August 2019 across theatres and wards.

We saw sharps bins were available in treatment areas where sharps may be used in line with Health and Safety Regulations 2013. We saw the sharps bins were not overfilled and the labels on sharps bins been completed by staff to ensure safe disposal.

Staff worked effectively to prevent, identify and treat surgical site infections. The hospital employed a full-time infection control and prevention nurse. They worked closely with the hospital’s microbiologist and pharmacist to oversee the prescribing of antibiotics.

The infection control and prevention nurse worked closely with staff and was available to give advice and support when required. We saw examples of this in patient records we reviewed.

Hospital data showed the service had reported 33 surgical site infections between September 2018 and August 2019. The majority of these (23) were attributed to orthopaedic procedures. Five of these were deep tissue infections, the rest were superficial infections. The service undertook an investigation into the five deep tissue infections to ensure any similarities were identified. The investigations included swabbing staff to identify if they were carrying any bacteria. The investigations showed all the bacteria’s that caused the infections were different and there were no similarities. For example, the same staff or theatre used. All patients completed a wound questionnaire after they were discharged from hospital which they posted back to the hospital. This ensured the service could capture any wound infections that developed after they were discharged from hospital.

The service also reported no incidents of *Clostridium difficile*, *Meticillin-resistant Staphylococcus aureus* blood cultures, *Escherichia coli* blood cultures or *Meticillin-susceptible Staphylococcus aureus*.

The service screened all patients for *Meticillin-resistant Staphylococcus aureus* as part of the pre-assessment process. All patients were risk assessed and high-risk patients which included those scheduled for orthopaedic

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surgery, those who had recently been in hospital were swabbed to test for Meticillin-resistant Staphylococcus aureus. This was in line with Department of Health guidelines.

In theatre we observed that the skin at the surgical site was prepared using an antiseptic solution immediately before the incision. This was in line with National Institute for Health and Care Excellence guideline [NG125] Surgical Site Infections: Prevention and Treatment April 2019.

We observed the risk of infection for patients who required a cannula was minimised by the completion of specific procedures during insertion of the cannula, its maintenance and its prompt removal when no longer required. A cannula is a straw like device inserted into a vein to give medicines or fluids. All patient records we reviewed showed cannulas were inserted, assessed and removed in line with National Institute for Health and Care Excellence Quality standard Infection prevention and control Quality Standard [QS61], April 2014.

Patient discharge information included information on the type of dressing they had on their wound. For example, when it needed to be changed.

The hospital undertook weekly water testing to check for the presence of Legionella bacteria and to check the temperature of water. We reviewed records which confirmed the water testing and flushing was undertaken. Legionella bacteria is commonly found in water. The bacteria multiply where temperatures are between 20-45°C and nutrients are available. The hospital identified an increase in positive Legionella results in water between November 2018 and July 2019. We saw corrective actions had been taken to address these results and additional testing undertaken. The issue was addressed through the water safety committee and further investigation showed and issue with the incorrect pipes being installed to the hospital by a contractor. These pipes were in the process of being replaced during our inspection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. We saw the correct segregation of clinical and non-clinical waste into different coloured bags, in line with national guidelines.

The service had enough suitable equipment to help them to safely care for patients. All the equipment we reviewed during the inspection had undergone electrical safety testing within the last year.

Emergency equipment and resuscitation equipment was regularly checked to ensure it was available and safe to use. We checked the equipment within the resuscitation trolleys on Nickleby ward, theatres and pre-assessment. All the electrical equipment had been serviced and tested for electrical safety within the last 12 months. We randomly selected a variety of single-use items and saw all were sealed and within their use-by-dates. Emergency medicines were within their use-by dates and within sealed packaging. We reviewed the trolley checklists which showed the trolleys were checked and defibrillators were checked daily.

Emergency equipment was easy to locate. In the recovery area we saw the location of emergency equipment was labelled on the wall above the equipment. If the equipment was in use elsewhere it was written on a wipeable sign above the equipment where it was and the where to go to get another if required.

Staff reported good access to technical support when there were problems with equipment. There was a technician within theatres who provided support with equipment. In theatres we saw one of the control panels was not working. This meant staff were unable to tell if there was an issue with the ventilation. However, it was monitored by the hospital's estates team remotely and took action if required. Staff told us that a number of the control panels had been replaced recently, and the faulty one would be replaced in the near future.

Staff in theatres ensured anaesthetic machine safety checks were undertaken and documented. We reviewed three anaesthetic machine logbooks which showed staff had checked the anaesthetic machine at the start of every theatre session. If the theatre was not in use, this was also recorded in the logbook. This was in line with national guidance from the Association of Anaesthetists of Great Britain and Ireland. The logbooks also showed the machine's breathing tubing was changed weekly in line with the manufacturer's guidelines.

The service maintained accurate records on medical implants. Batch numbers, expiry dates and sizes of

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implants were recorded onto a register which was then inputted into the national electronic implant databases. This allowed traceability of implants to help identify any issues with a particular batch.

The hospital undertook monthly tests of the hospital generator, this ensured the power supply to the hospital would continue in the event of a power cut. We saw records to confirm the generator was tested monthly.

We observed in theatre that absorbent pads were used on the floor to absorb excess fluid. For example, in the area where staff washed their hands to prepare for surgery. This represented a slip hazard as staff could slip on them as they were not designed to be used for this purpose.

On Havisham ward there was no designated box to put blood samples awaiting collection. This meant there was a risk that they could get lost. After the inspection the provider told us that each area had a designated box, with the ward name or department printed on it.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

We reviewed the root cause analyses for the serious incidents prior to the inspection. Concerns were identified in escalation of concerns, management of deteriorating patients and undertaking and the recording of neurovascular observations. During the inspection, we saw a number of actions had been taken to address these concerns and prevent a re-occurrence. Neurovascular means relating to or involving both nerves and blood vessels.

We saw a new neurovascular competency document and guidance tool had been introduced. Staff confirmed they had received training on undertaking neurovascular observations and the new observation chart and guidance.

All patients who had undergone surgery on a limb had neurovascular observations to monitor for signs of blood vessel or nerve damage. There were separate neurovascular observation charts and guidance for upper limbs and lower limbs. Staff took the first set of observations before surgery, so a base line set of observations could be used as a comparison. Staff assessed the following: the temperature, colour, pulse,

capillary refill, pain, sensation, movement and swelling of the limb. Each set of observations was rated depending on the observations; green, yellow or red. There was clear guidance on what action to take and how to undertake the observations on the chart. For example, any red score meant nursing staff must contact the consultant immediately and get advice in 30 to 60 minutes. The frequency of neurovascular observations undertaken was also documented on the chart. A set of neurovascular observations was undertaken at the same time as each set of routine observations.

We reviewed 12 neurovascular observation charts and found them all to be completed fully. The only exception to this was one chart which did not have a date on.

A staff member had presented an idea for a new test to be completed at pre-assessment for patients undergoing limb surgery which would identify patients with peripheral arterial disease. Peripheral arterial disease is a common circulatory problem in which narrowed arteries reduce blood flow to limbs. The hospital had a “Good to Outstanding” initiative which allowed staff to present new ideas to the senior leadership team. If successful and their idea was implemented, staff received an additional payment.

The new test implemented was the ankle brachial pressure index test which is used to diagnose peripheral arterial disease. We saw that the test was being undertaken in the pre-assessment area. Staff confirmed they had received training on how to perform the test. This ensured patients with peripheral arterial disease were identified and could undergo further investigations to check they were suitable to have an operation at KIMS Hospital or be needed to be referred to another hospital.

One of the root cause analysis investigations identified a patient was transferred from recovery to the ward when they were bleeding. As a result of this, the service had introduced a modified Aldrete's scoring system. This system is a commonly used scale for determining when people can be safely discharged from the recovery unit to the ward. In the 12 sets of patient records we reviewed we saw all had a score calculated and met the criteria to be discharged from recovery to the ward.

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We saw staff in theatres confirming that any female patients aged between 18 and 55 who had not had a hysterectomy had a negative pregnancy test on the morning of surgery. This was in line with National Institute for Health and Care Excellence guideline NG45.

The 12 sets of patient records we reviewed showed that a thorough pre-assessment for surgery had been undertaken. The type of pre-assessment was dependant on the patient. All patients completed a pre-assessment questionnaire this was reviewed by a pre-assessment nurse who decided on the type of assessment required. Pre-assessment was crucial to assess the suitability for surgery and to ensure any adjustments were made in order to treat the patient safely. In our previous inspection we highlighted that there was no hospital policy in relation to inclusion and exclusion of what patients could be treated at the hospital. The hospital now had an admission and discharge policy which was issued on July 2018. This policy set out criteria of the type of patients that could be admitted to the hospital for surgery.

We observed theatre staff carrying out the World Health Organisation surgical safety checklist however, we did not observe the debrief stage. The World Health Organisation surgical safety checklist is a national core set of safety checks for use in any operating theatre environment. The checklist consists of five steps to safer surgery. These are team briefing, sign in (before anaesthesia), time out (before surgery starts), sign out (before any member of staff left the theatre) and debrief. We observed the checklist was undertaken consistently and staff appeared fully engaged in the process. Staff told us that they felt able to raise concerns during the surgical safety checklist process. Each theatre team had a safety huddle at the beginning of the operating session to discuss equipment requirements, staffing levels, the list for the session and any relevant patient information. The theatre manager told us that a whole theatre team safety briefing was going to be implemented in the next two weeks. We saw an email trail which confirmed this. A whole team safety briefing would aid better communication and planning for the day and provide a forum to share lessons learned or issues from the previous day.

The service undertook monthly World Health Organisation surgical safety checklist audits to monitor compliance. Data

supplied to us by the hospital showed that between January 2019 and August 2019 100% compliance was achieved every month with the exception of August 2019 when 98% was achieved.

There was an electronic system used within theatres that tracked the patients journey through the different stages. Staff inputted times that different events started for example time the operation started. The time that the operation finished could not be entered until theatre staff had entered on the system that the sign out part of the World Health Organisation surgical safety checklist had been undertaken. This ensured relevant information regarding the operation and any instructions for their ongoing care were discussed and documented before the end time of the operation could be recorded.

The service used the national early warning system 2 (NEWS2). NEWS2 is a track-and-trigger early warning score system that is used to identify and respond to patients at risk of deteriorating. It is based on a simple scoring system in which a score is allocated to physiological measurements already undertaken when patients present to or are being monitored in health care settings.

We reviewed 12 NEWS2 charts and saw staff had completed all fully and calculated NEWS2 scores correctly. Three charts we reviewed had required escalation in line with guidance. We saw evidence within the notes that action had been taken and it had escalated to the resident medical officer who had reviewed the patients.

The service undertook monthly NEWS2 audits, 10 different patients NEWS2 charts were audited against 18 different measures to monitor compliance. Data supplied to us by the hospital showed 98% compliance against the 18 measures in August 2019.

Sepsis is a life-threatening, overwhelming response to an infection. The Royal College of Physicians recommend that sepsis should be considered in any patient with a NEWS2 score of five or more – ‘think sepsis’. One of the patient’s NEWS2 charts we reviewed had a score of five and had a high temperature however, a sepsis assessment proforma had not been completed. We asked the nurse in charge of the ward if the hospital had a set NEWS2 score which would prompt the sepsis assessment proforma to be completed and they told us it was five. The same nurse confirmed that the sepsis assessment proforma should have been completed. The patient’s records showed they had been

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reviewed by the resident medical officer promptly and further investigations and interventions completed however, there was no mention that sepsis had been considered as possible diagnosis. We spoke to the resident medical officer who told us they had considered sepsis as a diagnosis and had requested investigations based on this but did not explicitly write this in the patient's records. We saw that the resident medical officer had requested that blood culture samples were taken from the patient. However, there was a delay of two hours in these being taken as there was not any blood culture bottles on the ward. Blood cultures are used to detect the presence of bacteria or yeasts in the blood. The infection control and prevention nurse told us that as the blood culture bottles had a short shelf life they were not stored on every ward. The infection control and prevention nurse explained that they were stored in theatres and the nurse in charge had keys to the pathology department and could obtain them from there out of hours. The delay in obtaining blood samples did not have a negative impact on the patient.

The service had an up-to-date recognition, diagnosis and management sepsis policy which was based on national guidelines. The policy was supported by a sepsis 6 pathway and a sepsis assessment proforma. The sepsis 6 is a set six of interventions which can be delivered by any healthcare professional and must be implemented within the first hour of diagnosis or suspected diagnosis.

If patients were suspected on having sepsis an assessment proforma was completed. The assessment proforma was an algorithm for staff to follow based on clinical signs which then prompted them to undertake the sepsis 6 pathway if the patient had any red flags. We noticed the red flags did not include a high temperature which is a clinical feature in sepsis. We discussed this with the infection control and prevention nurse who said this was an oversight. On the same day the service removed the assessment proforma from all clinical areas and replaced it with an updated version which included having a high temperature as a red flag. Each ward had a sepsis box which contained equipment required for treating a patient with sepsis. On the front of the box was a laminated sheet with a checklist of the main clinical feature of sepsis and a high temperature was included.

The hospital kept a supply of O negative blood for use in emergencies. O negative blood can be given to the majority of patients in an emergency, if they experience excessive

blood loss. There was also an arrangement with a local trust called "code red". This meant when the "code red" was initiated blood products would be sent immediately to the hospital. Staff told us that the hospital had arranged scenario training of a "code red" with the NHS trust for October 2019 to test the process and identify any areas for improvement.

The 12 patient records we reviewed showed that patients had a variety of risk assessments undertaken. These included the risk of developing a venous thromboembolism (blood clot in a vein), pressure ulcer, risk of having a fall, moving and handling and the use of bed rails. We saw these were all fully completed, and the risk re-assessed, and measures put in place to reduce the risk.

For example, on one patient's pre-admission they had written they suffer with dizzy spells. We saw a falls risk assessment had been completed and the patient was assessed as a high risk for having a fall. We saw an actions had been put in place to reduce the risk, the patient had been informed to ring the bell every time they wanted to get out of bed. The patient was also wearing a green wristband which was a visual reminder to staff that the patient was at risk of having a fall. We saw notices in patient rooms which said, "call don't fall", which reminded patients to call for assistance rather than risk having a fall.

All 12 patients records we reviewed had a completed venous thromboembolism risk assessment and action taken to reduce the risk of developing a venous thromboembolism. For example, we saw patients were wearing anti-embolism stockings to reduce the risk of blood clots.

Data supplied to us by the hospital showed that between September 2018 and August 2019 on average 99.5% of patients had a venous thromboembolism assessment completed. This was almost equal to the hospital target of 100%.

There were five enhanced care rooms on Nickleby ward that the service used for any patients that needed a higher level of support after their operation. The rooms were allocated in advance for patients where a higher level of post-operative support was anticipated, such as a patient with a history of a heart condition. The rooms were also used for patients that deteriorated post operatively and required additional support. Additional monitoring was

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available in these rooms and they were close to the nurses' station to aid increased observation of patients. The monitors in these rooms were connected to a central monitor located at the nurse station. This ensured these patients could be monitored at all times. The staffing was planned to allow for the extra supervision and monitoring of patients in these rooms.

Staff who worked on Nickleby ward received additional training to ensure they had the skills and knowledge required. Topics included the recognition and treatment of an acute kidney injury and sepsis. The hospital leads for the topics delivered the training in addition to consultants. We were given an example of a "lunch and learn" session delivered by a consultant two days before our inspection. Staff we spoke to confirmed they had received additional training and felt they had the skills and knowledge required to care for patients requiring enhanced care.

Patients were given contact details of how to gain advice if they had any concerns after being discharged. The contact details were in their discharge pack which included a 24-hour contact number direct to the ward. We observed nursing staff ensuring patients had their discharge pack prior to leaving the ward.

The service had an effective system which ensured any surgical packs deliberately left in the body after the operation were recorded correctly to ensure they were removed. The scrub practitioner for the operation recorded within the patient's care pathway the time it was inserted, the location of the pack and when it should be removed. In addition, a pink patient identification bracelet was applied to the patient's wrist to act as a visual reminder to staff that the patient had a pack. Surgical packs are used to absorb fluid such as blood after surgery.

The hospital had a resuscitation team that would respond to any emergencies within the hospital. The team met twice daily in the morning and evening, so they could allocate roles in the event of an emergency and to check the full team was available. The team consisted of a senior nurse carrying the hospital bleep, resident medical officer, a porter and a member of the theatre team.

We reviewed service level agreements, regarding emergency transfers, between KIMS Hospital and local NHS trusts which were all in date. Initially a consultant at KIMS would refer the patient to a consultant at the receiving NHS trust. Once accepted by the NHS trust a KIMS Hospital's

resident medical officer would complete a transfer letter that clearly summarised the patient's history and an agreement would be made where to send the patient to. Either directly to critical care or to the receiving trust's emergency department. The agreement stated that KIMS Hospital would receive feedback on the welfare of the patient within 24 hours of transfer.

Depending on the condition of the patient either a consultant anaesthetist, senior nurse or resident medical officer would escort the patient.

The service undertook scenario training which was filmed to ensure staff maintained the skills and knowledge required to respond to an emergency in the hospital. Such as dealing with a cardiac arrest, by filming the scenario they were able to identify areas for improvement.

Nursing and support staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service employed 50 registered members of staff which were a mixture of registered nurses and operating department practitioners, eight administrative staff and 21 ward clerks. The service employed 58 bank staff.

At the time of the inspection there were three full time registered nurse vacancies. These vacancies had been filled and staff were due to start in October 2019. There was one ward care support worker vacancy.

Agency and bank staff were used to cover the vacant posts. The service tried to use the same agency staff who were familiar with the hospital's policies and processes. We saw agency staff had a thorough induction and for their first shift they shadowed a permanent member of staff.

The service measured agency use as a percentage of all clinical agency hours worked against total clinical hours for the month. The lowest use was 3.2% in February 2019 and the highest was 6.5% in May 2019.

The service had run an open day to recruit staff and any staff interested in working within the hospital were given a taster session by talking to staff and having a tour of the hospital.

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The number of nurses and healthcare assistants on all shifts at the time of our inspection on each ward matched the planned numbers. We reviewed rotas for the wards which confirmed this. Planned staffing and actual staffing levels were displayed on the wards.

We reviewed the theatre staff rotas, which showed there were two scrub practitioners, one scrub assistant, one anaesthetic practitioner, one healthcare assistant and 0.5 recovery staff for each theatre. This met with the Association for Perioperative Practice guidance for safe theatre staffing. We observed staffing levels were in excess of this guidance during our inspection.

Theatres had a 24-hour on call staff which consisted of two scrub practitioners, an anaesthetic practitioner and a support worker. This ensured there was sufficient staff available for any patients who needed to return to theatres out of hours. We reviewed rotas which reflected these staffing levels. The hospital required theatre staff to be within 30 minutes of the hospital whilst on call.

The service had developed their own staffing planner tool to ensure a sufficient number and skill mix of nursing staff on the wards depending on patient numbers and acuity. Additional staffing was planned if patients required enhanced care. One staff rota covered the staff for Nickleby and Hailsham ward.

Individual hand over of patients was undertaken at the bed side of the patient. After this, all staff met together for a full handover to discuss any issues, review staffing levels, discussed any patient risks and allocated breaks. We observed a nursing handover on Nickleby ward. Items discussed included patients to be discharged that day, physiotherapy input and patients at risk of falls or developing pressure ulcers.

Medical staffing

The service had enough medical staff to keep patients safe. The hospital's resident medical officers provided on-site doctor cover 24 hours a day, seven days a week. They were accessible via a bleep, this ensured staff could quickly escalate any issues concerning a patient. The resident medical officer escalated any concerns about a patient to the consultant.

The resident medical officers worked a rota of either one or two weeks on duty followed by one or two weeks off. We were told resident medical officers had a hand over at the

start of the week, but we did not observe one during our inspection. During busy periods, the hospital used two resident medical officers which ensured they had time to rest. A resident medical officer told us that if they had been busy in the night and were not able to rest, a replacement would be found.

In the records we reviewed we saw evidence of consultant review and discussions between the resident medical officer and the consultant. However, some staff told us that occasionally they had found it difficult to make contact with a consultant but if they left a message on their answer phone they returned the call promptly. No staff reported this having an adverse impact on the patient and consultants would always come into the hospital when requested.

One of the root cause analysis investigations identified that a message from ward staff who were concerned about a patient was not passed onto a consultant while they were in theatre. During the inspection we saw this issue had been addressed. There was a communication wipe board within theatres. At the beginning of each theatre session the names of the consultants present in theatres was written on the board, any messages staff got for them were written on the board. The same root cause analysis identified an issue with contacting a consultant. During the inspection the senior leadership team told us that this was being addressed via the World Health Organisation surgical safety checklist. During the team brief, consultants would be asked to provide the name of a covering consultant if they weren't available and this would be documented.

All staff knew how to access the consultant's telephone numbers and an administrator maintained the contact list to ensure it was up-to-date.

The service had an on-call anaesthetist available 24 hours a day should a patient have to return to theatre in an emergency. The hospital's practising privileges policy required consultant anaesthetists to be "immediately available, free of other commitments and resident within 30 minutes' drive of the hospital" while on-call. For patients receiving enhanced care, the treating anaesthetist was required to be available for support and advice for the first 36 hours after surgery. After 36 hours the on-call anaesthetist could be contacted for advice.

The hospital's practising privileges required all consultant surgeons to be available for 30 days after the patient's

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surgery. This ensured there was consultant input if required. As part of the hospitals' practising privileges each consultant had to name a "buddy" from the same speciality. The "buddy" covered any emergencies with a patient if the primary consultant was not available for example were on leave. Staff told us they had access to the "buddy" list and would contact a consultant's buddy if they experienced difficulties contacting the primary consultant.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, easily available to all staff providing care.

The majority of patient records were paper based. The service used an electronic system to manage appointments, discharge letters, theatre activity and diagnostics such as blood results and imaging.

During the inspection on Hailsham Ward, we observed some unattended patient records near the nurses' station. We raised this with the nurse in charge who confirmed if the area was unattended all patient records should be locked within the cabinet. The hospital's Senior Information Risk Owner was informed of our findings and took immediate action.

Two root cause analyses both identified incomplete or missing documentation within the patient records. A number of actions had taken place in response to the findings within the root cause analyses. The senior leadership team had set up a documentation working group led by two consultants and a senior nurse to improve the standard of documentation. Subsequent working groups in different areas had also been established for example within recovery.

The hospital had implemented a "theme of the week" which identified one aspect of documentation which required improvement. The theme was discussed at hand over, theatre briefings and at hospital briefings. One theme identified was signatures that could not be read and dating of entries within a medical records, so this became the theme of the week.

Patient records had been moved from ward offices into the patient rooms. This ensured staff could immediately write in the patient records after delivering care. Staff we spoke

with were positive about the change. Staff described previously that they might get distracted doing something else walking to the office to document in the patient notes, this way they documented everything straight away.

The service had changed the lay out of the paper records, with a colour coding system, an index and standardised layout making it easy for staff to access the information they needed.

We reviewed 12 sets of patient notes and found they were comprehensive, up-to-date, legible and staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. Risk assessments and care plans were fully completed.

The service undertook documentation audits on the wards, theatres and in recovery. Patient records were audited against a standard checklist in real time and completed or amended if required. Audit data showed between 24 July and 01 August 2019 compliance between 88% and 98% on Nickleby ward. The same data showed between 22 July and 01 August 2019 compliance between 92% and 99% on Copperfield ward and between 86% and 100% in theatres. We saw all non-conformities were discussed with staff at the time of the audit.

In July 2019 a "gatekeeper audit" had been introduced in recovery. Recovery staff undertook a real time audit of the documentation completed while the patient was having surgery prior to discharge to the ward. The audit checked 10 different things had been documented such as if the medicine chart had been completed or it was documented that the cannula had been flushed. If any of the 10 items had not been documented, the notes were returned to the theatre staff for completion. This ensured all aspects of care within theatres was correctly documented before the patient was discharged to the ward.

All hospital policies were stored and managed on an electronic based system and each policy had an individual identifiable number. Each policy had an author who was responsible for ensuring it was reviewed in line with hospital time frames. The system had a function which meant it was possible to tell if staff had opened the policy and read it. New staff had to confirm they had read the policy, understood it and would abide by it. Policies which had been updated were subject to the same process.

Medicines

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Staff followed systems and processes when safely prescribing, administering, recording and storing medicines including controlled drugs. Controlled drugs are medicines liable for misuse that require special management, therefore secure storage is vital to prevent unauthorised access to controlled drugs. Spot checks on balances of controlled drugs showed that contents of the cupboard matched the register.

Between September 2018 and August 2019, the service reported 14 incidents relating to medicines. Of these the top three themes were medicine was not given (three), errors with discharge medicines (two) and medicines given at an incorrect time (two).

We reviewed 12 prescription charts and saw staff documented relevant information including, allergies and weight. This ensured the correct doses of medicines were prescribed.

Medicines requiring cold storage were stored in dedicated fridges and fridge temperatures were recorded and centrally monitored by pharmacy staff.

Staff told us that they received good support from the pharmacy team. There was an on-call pharmacist available out of hours for advice or support. Daily stock checks of medicines were undertaken, and areas stocked up by the pharmacy team.

In one theatre fridge we found emergency medicines in a tray which were drawn up which were not dated or signed. We highlighted this to a member of staff who disposed of them immediately.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Between September 2018 and August 2019, the service reported 623 incidents, 517 (83%) were reported in ward areas, 106 (17%) were reported in theatres. The most

reported incident (24%) was conversion of a planned day case to inpatient, 6% were unplanned return visits to theatre and 1% were patients who developed venous thrombosis.

The department or ward manager undertook incident investigations and gave feedback to staff. There was a weekly hospital wide incident review meeting attended by the chief nurse, deputy nurse and quality and governance lead. All incidents reported in the past week were reviewed to ensure the severity of the incident was scored correctly, decide if any action needed to be taken immediately and to identify a lead investigator.

Between September 2018 and August 2019, the service reported five incidents resulting in serious injury. It was these incidents that triggered a responsive inspection as assurance was needed that the provider had taken corrective action. The service undertook root cause analysis investigations into all of these incidents. We reviewed four of the root cause analyses and found they had been fully investigated and made changes to practice, processes and policies to help prevent a recurrence. There was an action log for each root cause analysis investigation and actions were assigned to an individual staff member with time deadlines.

The investigations showed that staff involved in the incidents had been supported by managers, who had facilitated reflective sessions for the staff involved.

Staff told us that there was a culture of openness and transparency in learning from incidents and learning was shared. Staff were able to give us examples of changes as a result of the serious incidents. For example, one staff member told us about the training they had received to undertake neurovascular observations and the new assessment proforma.

We saw learning from incidents was shared with staff via, departmental meetings, KIMS Voice staff forum, "10 at 10" daily briefings, newsletters and emails. We reviewed departmental meeting agendas and meeting minutes which all had incidents, accidents and lessons learnt as standard agenda items. Learning from the serious incidents and cascading of changes as a result of the incidents was included in agendas and meeting minutes.

The service had no never events between September 2018 and August 2019. Never events are serious patient safety incidents that should not happen if healthcare providers

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follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour regulation. The service reported five incidents which met the duty of candour threshold between September 2018 and August 2019 and we reviewed documents which confirmed the regulation had been applied.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Between September 2018 and August 2019, the service reported 99.8% harm free care.

Data from the Patient Safety Thermometer showed that the hospital reported six hospital acquired venous thrombosis and pulmonary embolisms, two new pressure ulcers, four falls with harm and no new catheter urinary tract infections between September 2018 and August 2019 for surgery.

Are surgery services effective?

Good 

Effective was rated as good at the previous inspection in 2018. As this was focussed inspection we did not inspect effective.

Are surgery services caring?

Good 

Caring was rated as good at the previous inspection in 2018. As this was focussed inspection we did not inspect caring.

Are surgery services responsive?

Good 

Responsive was rated as good at the previous inspection in 2018. As this was focussed inspection we did not inspect responsive.

Are surgery services well-led?

Good 

As this was a focussed inspection we did not change the rating for well-led. At the last inspection in 2018 well-led was rated good.

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service. They supported staff to develop their skills and take on additional roles. Leaders listened to staff and were or had taken actions to address concerns raised.

The hospital had a structured senior management team led by the chief executive officer. The medical director and chief nurse reported to the chief executive. The ward sisters reported to the deputy chief nurse, who subsequently reported to the chief nurse. The theatre manager reported directly to the chief nurse. Staff in sterile services as well as theatres reported to the theatre manager.

The senior leadership team had quickly informed CQC about the serious incidents and had taken decisive action taken to mitigate the risk and to prevent a reoccurrence. The senior leadership team had ensured structured root cause analyses had been undertaken and maintained

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oversight of the actions resulting from these. They ensured changes were made quickly and staff were provided with opportunities for reflection and provided support and additional training if required.

The senior leadership team had actively sought external scrutiny to support their analysis and had ensured learning had been shared both internally and externally. In addition, they had researched and were in the process of implementing two accredited programmes to support wider issues identified within the root cause analysis.

All staff spoke positively about their relationships with both their line manager and the senior management team. Staff felt able to escalate any issues to the senior management team if needed.

Managers who led a ward or department had completed an accredited qualification in leadership and management. This helped them to develop their skills and experience, improve performance and prepare for senior management responsibilities.

The chief executive officer and the chief nurse both sponsored managers to develop their skills and knowledge and held monthly coaching sessions with them. For example, the chief executive officer sponsored the theatre manager who shared with us the areas of coaching being worked on. Coaching sessions were booked a session a month and were booked 12 months in advance to ensure they were completed.

Vision and strategy

The service followed the hospital's mission and values. The hospital's mission was "to provide the highest quality of care in a world-class clinical environment for the people of Kent". The values were caring, confident, dynamic, respecting people, and operating and communicating with integrity as a team to bring quality and value. Staff we spoke with knew the hospital values and had them printed on a card with their identity card to serve as a reminder. We saw staff adhered to these values in every interaction with patients and staff.

The hospital had some key strategic objectives with patients as the centre for these. The objectives were commercial success, working together as one team-making KIMS hospital a great place to work and providing safe, outstanding quality care for their patients.

Culture

Staff felt respected, supported and valued. Staff were focussed on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The senior leadership team maintained an open and transparent attitude. They acknowledged that changes as a result of the serious incidents were not yet fully embedded and some "ironing out" of some of the processes was still required. For example, the issue highlighted in one of the incidents when a consultant was not immediately contactable on the telephone when complications arose involving a patient under their care. This was going to be addressed as part of the World Health Organisation safety checklist.

An action from the incidents was the hospital was implementing the accredited "Speaking-up for safety™" programme. The programme was an organisation-wide programme to build a culture of safety by empowering staff to support each other and raise concerns. The chief executive officer and chief nurse were the sponsors for the programme supported by two project leads. The project was a "train the trainer" model and six staff members were starting the two-day programme at the end of September 2019. It was hoped the six staff members would be accredited by the end of November 2019 and then the team of six would provide a one-hour training session to all hospital staff. The training for staff would be prioritised for key departments such as theatres and wards, the aim was to have all staff trained within 10 months of the launch of the programme.

The hospital was also implementing was the "Promoting professional accountability" programme. This programme provides a framework for defining safety and professionalism standards, and identifying, measuring and addressing behaviours that undermine them. The programme was planned to run alongside "Speaking-up for safety™" programme and aimed to embed an organisation-wide speaking up culture.

The hospital embraced a one team culture. Leaders were developing a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. We found this culture was embedded during our inspection. One health care assistant told us "we have team

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spirit, I am treated equally, and there is no feeling of hierarchy". In the December 2018 hospital staff survey 85% of staff said, "the hospital provides equal opportunities for career progression or promotion".

Staff described the senior management team as being visible and approachable. Staff told us about the chief executive officer "I don't know how he does it, but he knows everyone's name". Another member of staff told us that they were approached by the chief executive on their first day in the hospital as he wanted to introduce himself to them. The chief executive officer ate lunch in the hospital's "Bistro" and sat and talked to staff. This showed the open and accessible culture we observed throughout our visit.

All the staff we spoke with said they enjoyed their job. Staff were proud of the organisation as a place to work and spoke highly of the culture. In the December 2018 hospital staff survey, 90% of staff responded, "I see myself still working here in one year's time".

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations.

Staff at all levels were clear about their roles and accountabilities. The hospital had governance systems for identifying risks, and which provided a systematic approach to improving quality and safety of care.

The hospital had a quality and governance strategy for 2018 to 2021. There were nine quality objectives defined and detailed, within the strategy, including how outcomes would be monitored and measured, maintaining and exceeding staff and patient satisfaction, reaching CQC outstanding across all core services and working creatively with partners to develop and maintain our high-quality services. The overall purpose of the strategy was to develop, and continually improve the quality and safety of services at KIMS Hospital.

The hospital's quality and governance committee, chaired by the chief nurse, met monthly and provided assurances around quality and safety to the hospital executive team. The hospital executive team consisted of the executive chair, the chief executive, the chief nurse, the medical director, the human resources director, the finance director, the commercial director and the communications and marketing director.

A variety of sub-committees such as medicines management, infection prevention and control and clinical effectiveness fed into the clinical governance committee. A report amalgamating information and data from all sub-committees was presented at the clinical governance committee meetings and medical advisory meetings. The chairs of the sub-committee chairs sat on the quality and governance committee, which gave assurances to the board.

The medical director chaired the medical advisory committee which held quarterly meetings. The chief executive officer and chief nurse also sat on the medical advisory committee. The medical advisory committee provided the formal organisational structure through which consultants communicated. Consultant anaesthetists and surgeons were all representatives of the medical advisory committee. This committee's purpose was to act as a point of contact and information for consultants, ensure that policies and procedures support the delivery of safe and effective clinical care and support the development of the overall clinical strategy of the hospital.

The hospital's morbidity and mortality committee met quarterly and we reviewed the minutes of the last three meetings. We saw that the committee reviewed unplanned transfers to hospitals and return to theatres as a standard agenda item. Representatives from theatres, pharmacy, the resuscitation team and enhanced care lead attended the meetings, the minutes showed no consultants attended. This meant consultants might have missed the opportunity for multidisciplinary review of patients transferred to another hospital or returned to theatre.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events such as adverse weather.

Leaders used electronic systems and performance dashboards to manage current and future performance. These allowed the senior leadership team to have an effective system to identify, monitor, understand and address current and future risks. This was supported by a detailed risk register, which reflected issues that staff and

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the senior leadership team told us they were concerned about. There were clear process and systems for leaders to escalate risk and performance issues via sub-committees and to the hospital's executive team.

The hospital had a comprehensive quality dashboard, which monitored monthly performance in a range of areas relating to surgery. These included but was not limited to; World Health Organisation safer surgery checklist, national early warning score 2, surgical site infections and unplanned returns to theatre. The hospital had set targets for each indicator based on national standards where applicable. We reviewed the quarterly Quality Governance sub committee meeting minutes for March, June and September 2019. The meeting minutes showed the quality dashboard was reviewed and any areas for improvement identified with actions.

The hospital had an effective system for granting of practising privileges of consultants. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic. We reviewed three consultant files and found a good standard of documentation to support the granting of practising privileges. Files included all the documentation outlined within the hospital's practising privileges policy.

The hospital required consultants to re-apply for their practising privileges a minimum of every two years. The three consultant files we reviewed included the documents to support re-application supported by the medical director, who reviewed all applications.

One essential element of granting of practising privileges was ensuring the hospital had an up to date scope of practice for each consultant. This ensured all staff were aware of any one consultants scope of practice to ensure that only those procedures that were covered within their scope were carried out within the hospital. To ensure for consultants was considered before a procedure was carried out a 'Triple lock' process had been introduced. The process was effective in ensuring consultants only performed operations within their statement of purpose that they were competent to perform.

Managing information

The service collected reliable data and analysed it.

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and

improvements. A new patient management system had recently had an upgrade to incorporate new functions. Staff told us that there had been some teething issues. There were champions within the hospital who staff could contact for advice and support. In addition, drop in sessions had been organised. The information systems used were secure.

The majority of patient records were still paper based; the hospital planned to change over to an electronic patient record system in two years' time.

On the whole, staff reported easy access to the IT systems and that there were enough computer terminals available.

The hospital was actively engaging with NHS digital and working towards the NHS digital data and technology standards.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. The hospital engaged with local multi-agency networks such as clinical commissioning groups and safeguarding networks.

The hospital had a staff forum called "KIMS Voice" which met monthly. The chief executive officer or the chief nurse attended. We observed one of these forums, breakfast was supplied for staff and they were well-attended by all grades of staff. Staff were positive about the forum, we reviewed the previous meeting minutes which showed a variety of subjects were discussed. These included but were not limited to; uniform requirements, catering survey, summer fun day and car park security. We saw actions were taken by the executive team as a result of staff raising issues in this forum. For example, a higher fence had been installed in the car park to improve staff safety and the installation of more lockers for staff to use.

The chief executive officer delivered briefings every six months to inform staff of any changes that might affect them.

To engage with the local community, the hospital had a nominated local charity that they raised funds for each year. Staff were able to propose a charity to support and staff voted for the charity that would be supported. Events for the charity included a summer fun day and a sponsored walk.

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They had a Macmillan cancer support group which was set up in February 2018. It was open to all cancer patients and their families and carers. The Macmillan Breast Clinical Nurse Specialist organised and ran the group, booking speakers and welcoming those that attend each month.

The last hospital survey (December 2018) staff survey had an 81% response rate and 99% staff engagement score. The hospital produced quarterly newsletters called “Connect” to share information with staff.

To ensure all staff had an opportunity to voice any concerns confidentially, KIMS Hospital had designated ‘Freedom to Speak Up Guardians’ who could be contacted at any time for confidential conversations and advice. We saw posters and screen savers which explained the role of the ‘Freedom to Speak Up Guardians’.

KIMS Hospital had introduced three mental health first aiders to ensure mental health and wellbeing of all staff, giving them somewhere confidential and supportive to turn to when required. The first aiders had received additional training in how to support and signpost staff who may be experiencing a mental health illness.

In the last hospital staff survey (December 2018), 95% of staff answered yes to the question “Does your organisation take positive action on health and wellbeing”?

In 2018 KIMS Hospital was the winner of the Kent Excellence in Business Awards employer of the year award.

The senior leadership team gave examples of how they had made adjustments for staff when they returned from an extended period of sickness and flexible working. However, we noted that there was a lack of forums or groups to promote equality and diversity for staff and patients. For example, Lesbian, Gay, Bisexual and Transgender + forums.

Workforce Race Equality Standard (WRES) The Workforce Race Equality Standard (WRES) first came into effect on 1st April 2015 to monitor and address race inequality within healthcare provider organisations across the UK. The hospital had collected and submitted data to WRES in 2017 and 2018. In 2018 they collected and submitted data across all nine indicators for the 12-month reporting period. Key actions to date focussed primarily on increasing the proportion of staff who had self-reported their ethnicity. This increased from 82% in 2017 to 95% in 2018.

The hospital also provided different ways for service users to provide feedback. These included day case/inpatient questionnaires their website and via social media.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The hospital had undertaken comprehensive investigations into the serious incidents and identified learning and changes to practice were required. There were sponsors for some of the changes this ensured there was senior oversight of any challenges and ensured the time frame was met. All staff we spoke with were aware of the serious incidents and could give examples of learning from them. The senior leadership team demonstrated they were committed to ensuring the learning was shared outside of the hospital.

The hospital had a “Good to Outstanding” initiative which allowed staff to present new ideas to the senior leadership team. If successful and their idea was implemented, and staff received an additional payment.

Successful initiatives included day-case assessment revamp, refining staff uniform management, family history cancer screening, increasing efficiency in reservations, enhancing the joint school experience, improving care with ice therapy, improving lower limb outpatient assessment and reducing plastic bag use for patient property.

We saw in the pre-assessment there was a notice board which had information on what the department was doing well on, what their focus was and what they needed to improve on. For example, it said they needed to improve on finding time to get together for reflection on positive and constructive feedback.

The hospital was commitment to developing the career path for clinical staff and developing new innovative clinical roles. This included preceptorships for new nurses, return to nursing and student nurse placements.

A new corporate induction was launched that had helped streamline processes and ensured consistency, safety and quality. Both the chief executive officer and chief nurse delivered sessions at the induction and feedback from staff on induction was positive.

Outstanding practice and areas for improvement

Outstanding practice

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giving them somewhere confidential and supportive to turn to when required. The first aiders had received additional training in how to support and signpost staff who may be experiencing a mental health illness.

Areas for improvement

Action the provider **SHOULD** take to improve

The provider should ensure staff knew when to complete the sepsis screening tool.

The provider should ensure all patient records are kept securely.

The provider should ensure there are designated boxes to place blood samples in.

The provider should ensure staff know where to obtain blood culture bottles from.

The provider should ensure all unused medicines are disposed of at the end of each day.

The provider should seek assurance equality and diversity was promoted across the organisation.